Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date June 23, 2022
Inspection Number 2022_1119_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Extendicare Van Daele

Long-Term Care Home and City
Extendicare Van Daele, Sault Ste, Marie, ON

Lead Inspector
Lisa Moore (613)

Inspector Digital Signature
Lisa K Moore
Digitally signed by Lisa K Moore
Date: 2022.06.23 13:36:35 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 13-16, 2022.

The following intake(s) were inspected:

- Intake (Complaint) related to concerns regarding the provision of care
- Two intakes related to a resident fall resulting with a change in status and transfer to the hospital.

The following **Inspection Protocols** were used during this inspection:

- Resident Care and Support Services
- Falls Prevention and Management
- Infection Prevention and Control (IPAC)

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6. (9) 1

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for a resident.

Rational and Summary: The "Documentation Survey Report" for bathing, identified that a resident was scheduled for bathing on two specific days weekly. There was no documentation to identify that a resident's scheduled bathing had been provided for a two week time period.

Acting Director of Care confirmed there was no documentation to identify if a resident had received their scheduled bathing for two weeks in a specific month and stated that staff were expected to document the care provided.

There was low risk to residents when the documentation of their provision of care was not completed.

Sources: Resident's health care records; progress notes; Documentation Survey Report; and interviews with the Acting DOC and other staff.

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WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 50. (2) (a) (ii)

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered staff upon their return from hospital.

Rationale and Summary: A resident had a fall resulting in an injury and transfer to the hospital. There was no documentation in the resident's health care record to indicate that the resident had received a skin assessment by a member of the registered staff upon their return from the hospital.

Acting DOC confirmed that a skin assessment was not done or documented as it should have been for the resident's return form hospital.

There was low risk to the resident when the member of the registered staff did not complete a skin assessment.

Sources: Critical incident report, resident's health care record, progress notes and assessments: interviews with Acting DOC and other staff.

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